Name:		SSN or EIN:		Claimant #:	

GCCF 2000-I	GULF COAST CLAIMS FACILITY INTERIM PAYMENT CLAIM FORM

This Interim Payment Claim Form is to be completed for individuals or businesses who wish to receive payment for an **Interim Claim** for damages suffered as a result of the Deepwater Horizon incident on April 20, 2010, and resulting oil discharges ("the Spill").

A claim for Interim Payment is for PAST DAMAGES ONLY. Future losses or damages will NOT be included in an Interim Payment and they cannot be included on this Interim Payment Claim Form. You will not be required to execute a Release or waive any rights in order to file a claim for an Interim Payment or to receive an Interim Payment. To learn more about filing a claim for an Interim Payment, go to www.gulfcoastclaimsfacility.com, call toll free at 1-800-916-4893, or visit a Gulf Coast Claims Facility ("GCCF") Claims Site Office.

You may file an Interim Payment Claim only each quarter of each calendar year throughout the duration of the GCCF Claims Process, which terminates on August 22, 2013, or until you file a Final Claim. The first quarter begins now and concludes on March 31, 2011. Subsequent quarters will be April 1 through June 30; July 1 through September 30; and October 1 through December 31 of each year. Your Loss Measurement Period for each claim will conclude at the end of the month of the most recent actual financial data that you provide to the GCCF.

Send me all future communications and notices in the following language: (check only one box)

English ☐ Spanish ☐ Vietnamese ☐ Khmer ☐

Indicate whether you have previously filed a claim: (check only one box)

I previously filed a Claim with the GCCF ☐ I am a new Claimant to the GCCF ☐

SECTION I. INSTRUCTIONS

1. If you previously filed a claim for Emergency Advance Payment, you MUST indicate your existing GCCF Claimant Identification Number at the top of each page of this Form.

   If this is the first claim you are submitting to the GCCF, the GCCF will assign you a Claimant Identification Number. **That Claimant Identification Number will allow you to track the status of your claim online and will be your Claimant Identification Number throughout the claims process.**

   You can obtain information about your claim online at www.gulfcoastclaimsfacility.com, by calling the GCCF number at 1-800-916-4893, or in person at a GCCF Claims Site Office.

2. If you are an Individual Claimant, enter your Social Security Number in the box at the top of each page. If you are a Business Claimant, enter your Employer Identification Number in the box at the top of each page.

3. The Claimant must print the name of the Individual or Business Claimant and sign and date the Claim Form in Section VIII.

4. You may fill out and submit an Interim Payment Claim Form and provide supporting documents to the GCCF online by visiting the GCCF's website at www.gulfcoastclaimsfacility.com, or by mail, email, overnight delivery, fax or in person. If you submit your Interim Payment Claim Form online, you must submit all supporting documentation within five (5) days of your online filing. If you submit your Interim Payment Claim Form by mail, email, overnight delivery, fax or in person, you must submit all supporting documentation with your Claim Form. Claim applications and supporting documentation that are submitted in person are not retained at the GCCF Claims Site Offices. These materials are sent to the GCCF processing center in Dublin, Ohio, or are scanned and sent to the processing center via the internet.

5. If you previously filed a Final Claim Form and now wish to file an Interim Payment Claim, please check this box and proceed with the completion of this Interim Payment Claim Form in accordance with the Instructions above. ☐

Name:		SSN or EIN:		Claimant #:	

SECTION II. CLAIMANT INFORMATION

II.A. Individual Claimant Information

Provide the following information about the person who was affected or injured by the Spill. **All individual claimants must complete each question in this section.** (If you are filing for a business, skip this section and proceed to Section II.B.)

1. Name:	Last	First		Middle Initial
2. Current Address:	Street			
	City		State	Zip Code
	Parish/County		Country	
3. Home Phone Number:	(___) ___-____			
4. Cell Phone Number:	(___) ___-____			
5. Email Address:				
6. Date of Birth:				
7. Social Security Number: ☐ *or* **Individual Taxpayer Identification Number:** ☐	___-__-____			
8. Other Name Used (Maiden Name, Previous Married Name(s), Aliases):				

Provide complete information about your employment status since January 1, 2010 (add more pages if necessary):

9. Current Employer:	Name	Period of employment	
	Street	_____ to: _____	
	City	State	Zip Code
	Parish/County	Country	
	Employer Identification Number (EIN) __-_____ *(from your W-2 or 1099 form)*		
Other/ Previous Employer:	Name	Period of employment	
	Street	_____ to:_____	
	City	State	Zip Code
	Parish/County	Country	
	Employer Identification Number (EIN) __-_____ *(from your W-2 or 1099 form)*		

10. Does the Claimant own any part of a business listed in Question 9 and/or serve as an officer in the business? If so, name the applicable business and check either or both boxes below and specify the percentage of ownership and/or the office held:

Name of Business: _____

☐ Owner *(specify percentage)*:_____ ☐ Officer *(specify title)*:_____

Name:		SSN or EIN:		Claimant #:	

II.B. Business Claimant Information

Provide information in Section II.B. **ONLY if you are completing this Form for a business that was affected by the Spill.**

II.B.1. Information about the Business

11. Name of Business:				
12. Type of Business:				
13. Business Address:	Street			
	City		State	Zip Code
	Parish/County		Country	
14. Phone Number:	(___) ___-____			
15. Website Address:				
16. Other Business Name:				
17. Name of Business on Federal Income Tax Return:				
18. Employer Identification Number (EIN): ☐ *or* **Check here if EIN is also your Social Security Number** ☐	__-_____			
	___-__-____			
19. Date and Place Founded/Incorporated:	Date:_____ Place:_____			

II.B.2. Information about the Authorized Business Representative

20. Name:	Last	First		Middle Initial
21. Title:				
22. Home Address: (if different from Business Address)	Street			
	City	State	Zip Code	Country
23. Phone Number:	(___) ___-____			
24. Cell Phone Number:	(___) ___-____			
25. Email Address:				
26. Social Security Number: ☐ *or* **Individual Taxpayer Identification Number:** ☐	___-__-____			
	__-_____			

Name:		SSN or EIN:		Claimant #:	

SECTION III. ATTORNEY INFORMATION

Complete this section only if you are represented by a lawyer for this Interim Payment Claim. **If you complete this section, all communications from the GCCF will be with the lawyer you have identified unless your lawyer instructs us otherwise in writing. You must complete each question in this section if you are represented by a lawyer. Previous information provided about Attorney Representation will not apply to this Interim Claim.**

27. Lawyer Name:	Last		First	Middle Initial
28. Law Firm Name:				
29. Law Firm Address:	Street			
	City	State	Zip Code	Country
30. Law Firm Phone Number:	(__| __| __|) __| __| __| - __| __| __| __|			
31. Law Firm Email Address:				

Name:		SSN or EIN:		Claimant #:	

SECTION IV. CLAIM INFORMATION FOR INTERIM PAYMENT

Check which Claim Type(s) you want to submit. Enter the amount you are claiming for each Claim Type. If you have previously received a payment, do not include that amount in the amount you are requesting. **All claimants must complete this section.**

For each Claim Type you submit, you must provide documentation to support your claim. The documents you must provide are described on The Gulf Coast Claims Facility Document Requirements accompanying this Claim Form. (You are not required to resubmit the documentation submitted with your Emergency Advance Payment Claim.) Your damages will be calculated only for the period(s) for which you provide the required documentation.

You must provide documentation or evidence of the damage or injury for each Claim Type checked. You must submit this completed form to the GCCF along with supporting documentation. The Gulf Coast Claims Facility Document Requirements accompanies this Interim Payment Claim Form and lists the REQUIRED supporting documentation you must submit to support each Claim Type. Claims submitted without adequate supporting documentation will not be evaluated until receipt of required documents. Deficiency notices will not be sent to claimants submitting an Interim Payment Claim.

IV.A. Claims for Removal and Clean Up Costs

☐ CLAIMANT IS SUBMITTING A REMOVAL AND CLEAN UP COSTS CLAIM FOR $_____

Check the box above and enter the amount of your claim if you are seeking to recover costs incurred to remove oil discharged by the Spill and/or costs to prevent, minimize or mitigate oil pollution when there was a substantial threat of a discharge of oil due to the Spill. You can claim costs for both preventative and clean up measures.

If you are claiming multiple removal and clean up actions and need additional pages, photocopy this page before filling it in and attach the copy to this Claim Form for submission. Make as many copies as you need.

If you need more space to answer any questions, please use a blank page and attach it to this Claim Form for submission.

(A.1)	**Was the Removal and Clean Up action taken approved by the Federal On-Scene Coordinator and/or consistent with the National Contingency Plan?**	☐ Yes ☐ No

(A.2) Provide the address where the Removal and Clean Up action took place:

Street		
City	State	Zip Code
Parish/County		

(A.3) Provide a description of the Removal and Clean Up action:

Name:		SSN or EIN:		Claimant #:	

IV.B. Claims for Real or Personal Property Damage

☐ CLAIMANT IS SUBMITTING A REAL OR PERSONAL PROPERTY DAMAGE CLAIM FOR $_____

Check the box above and enter the amount of your claim if you are seeking damages for any physical damage to real, personal or business property that you own or lease.

If you are an owner of a property that you lease to someone else, you must notify the lessee that you are submitting a claim. If you lease property from someone else, you must notify the owner that you are filing a claim.

If you suffered damage to more than one piece of property and need additional pages, photocopy this page before filling it in and attach the copy to this Claim Form. Make as many copies as you need. Identify the type of Personal Property that was damaged or destroyed (*i.e.*, boat, equipment, machinery) and, if applicable, the make, model, year and identification number.

If you need more space to answer any questions, please use a blank page and attach it to this Claim Form for submission.

(B.1) If you are claiming damage to Real Property, provide the address of the property. If you are claiming damage to Personal Property, provide the address where the damage occurred:

Street

City | State | Zip Code

Parish/County

(B.2) If you are claiming damages to Personal Property, list the type of Personal Property that was damaged (*i.e.* boat, equipment, machinery) and provide the additional information, as applicable:

Type of Personal Property

Make | Model

Year | Identification Number

(B.3) Describe your relationship to the Real or Personal Property: ☐ Owner ☐ Lessor

Name:		SSN or EIN:		Claimant #:	

IV.C. Claims for Lost Earnings or Profits

☐ CLAIMANT IS SUBMITTING A LOST EARNINGS OR PROFITS CLAIM FOR $_____

Check the box above and enter the amount of your claim if you are seeking damages for lost earnings or profits due to the Spill. Individual claimants seeking lost earnings or profits must complete questions C.1.– C.7. Business claimants seeking lost earnings or profits must complete questions C.8.– C.15.

If you need more space to answer any questions, please use a blank page and attach it to this Claim Form for submission.

IV.C.1. Questions for Individual Claimants Seeking Lost Earnings or Profits

(C.1) State the occupation and job title you had at the time of the Spill:

Occupation | Title

(C.2) Describe the nature of business of your employer at the time of the Spill:

(C.3) State the total lost earnings you have suffered as a result of the Spill to date and describe how you have calculated these losses:

(C.4) Describe in detail the efforts you have made to find employment since the Spill:

(C.5) State the amount of any job hunting expenses you have incurred since the Spill: $_____

(C.6) Provide a description of how the Spill caused your losses:

Lost my Job: ☐ **Work Hours Reduced:** ☐ **Pay/Tips Reduced:** ☐

(C.7) Provide the name and address of your Employer at the time of the Spill:

Name

Street

City	State	Zip Code

Parish/County

Name:		SSN or EIN:		Claimant #:	

IV.C.2. Questions for Business Claimants Seeking Lost Earnings or Profits

(C.8) State the sources of income or types of customers for the business at the time of the Spill:

(C.9) Describe the nature of business at the time of the Spill:

(C.10) Describe in detail any efforts you have made to increase revenues or reduce costs since the Spill:

(C.11) State the total amount in operating costs you have saved (or were able to avoid) as a result of reduced operations since the Spill: $_____

(C.12) State the total loss in revenues the business has suffered as a result of the Spill to date and how you have calculated those losses:

(C.13) State the total loss in profits the business has suffered as a result of the Spill to date and how you have calculated those losses:

(C.14) Provide a description of the loss the business sustained as a result of the Spill and how the loss occurred:

(C.15) Provide the business address where the loss occurred:

Street		
City	State	Zip Code
Parish/County		

Name:		SSN or EIN:		Claimant #:	

IV.D. Claims for Loss of Subsistence Use of Nature Resources (Individual Claimants only)

☐ CLAIMANT IS SUBMITTING A LOSS OF SUBSISTENCE USE OF NATURAL RESOURCES CLAIM FOR $_____

Check the box above and enter the amount of your claim if you suffered damages to your ability to rely, without purchase, on natural resources for food, shelter, clothing, medicine or other minimum necessities of life because of the Spill. Identify below in Section D.2 the natural resource that you relied on for subsistence prior to the Spill, and how it has been affected by the Spill.

If you need more space to answer any questions, please use a blank page and attach it to this Claim Form for submission.

(D.1) Provide a detailed description of the loss of subsistence use you sustained as a result of the Spill:

(D.2) Identify the natural resource that you relied on for subsistence prior to the Spill and how it has been affected by the Spill:

(D.3) Describe how frequently you use this natural resource for subsistence and its approximate monthly value to you:

Name:		SSN or EIN:		Claimant #:	

IV.E. Claims for Physical Injury or Death (Individual Claimants only)

☐ CLAIMANT IS SUBMITTING A PHYSICAL INJURY OR DEATH CLAIM FOR $_____

Check the box above and enter the amount of your claim if you are seeking damages for physical injury or death proximately caused by the Spill or the explosion and fire associated with the Deepwater Horizon incident on April 20, 2010.

If you need more space to answer any questions, please use a blank page and attach it to this Claim Form for submission.

(E.1) Were you working for the Vessels of Opportunity at the time your physical injury occurred? ☐ Yes ☐ No

(E.2) Were you working on the Removal and Clean Up actions at the time your physical injury occurred? ☐ Yes ☐ No

(E.3) Provide the date you were first injured and whether the injury is resolved or ongoing: Date ☐ Resolved ☐ Ongoing

(E.4) If you are seeking damages for death, provide the name of the decedent and the date of the death: Name Date

(E.5) Provide a brief description of the physical injury sustained as a result of the Spill, and how the injury occurred:

(E.6) Provide the address where the injury was experienced:

Street

City State Zip Code

Parish/County

Name:		SSN or EIN:		Claimant #:	

SECTION V. COLLATERAL SOURCE COMPENSATION

All claimants must complete this section. You must complete this section to provide information on unemployment benefits, private insurance or any other replacement income received relating to any Claim Type. (Legally authorized garnishments, liens, or similar forms of attachments relating to your claim will be honored and deducted from your payment.)

32. Have you received any compensation from BP for your losses due to the Spill?	☐ Yes ☐ No
33. Total amount of compensation received from BP for your losses due to the Spill:	$
34. Have you received any compensation from GCCF for your losses due to the Spill?	☐ Yes ☐ No
35. Total amount of compensation from GCCF for your losses due to the Spill:	$
36. Have you received compensation for state unemployment benefits?	☐ Yes ☐ No
37. For what period of time did you receive compensation for state unemployment benefits?	
38. Total amount of unemployment benefits received:	$
39. Have you received compensation from private insurance for damages due to the Spill?	☐ Yes ☐ No
40. Name of Carrier or Provider:	
41. Account or Policy Number:	
42. For what period of time did you receive compensation from private insurance?	
43. Total amount of insurance benefits received:	$
44. Have you received any other replacement income, such as severance pay?	☐ Yes ☐ No
45. For what period of time did you receive this other replacement income?	
46. If you are still receiving this other replacement income, when will these benefits end?	
47. Total amount of other replacement income received:	$

Name:		SSN or EIN:		Claimant #:	

SECTION VI. REPRESENTATIVE CLAIMANT INFORMATION

You must complete each question in this section if you are filling out this Claim Form for an Individual Claimant affected or injured by the Spill who is deceased, is a minor, or is incompetent or legally incapacitated and unable to complete the Claim Form for himself or herself. (You must provide proof that you are a duly appointed Representative.) See Section VII of the Gulf Coast Claims Facility Document Requirements for the documents required to establish authority to act as the Representative Claimant or visit the website at www.gulfcoastclaimsfacility.com. **Business claimants do not complete this section.**

48. Reason person affected or injured by the Spill is unable to complete the Claim Form:	
49. Your relationship to Claimant:	☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Administrator ☐ Executor ☐ Other (specify): _____

Provide *your* name and contact information below.

50. Last Name:				
51. First Name:				
52. Middle Name:				
53. Current Address:	Street			
	City	State	Zip Code	Country
54. Home Phone Number:	(___|___|___) |___|___|___| - |___|___|___|___|			
55. Cell Phone Number:	(___|___|___) |___|___|___| - |___|___|___|___|			
56. Email Address:				
57. Social Security Number: ☐ *or* **Individual Taxpayer Identification Number:** ☐	|___|___|___| - |___|___| - |___|___|___|___| |___|___|___| - |___|___| - |___|___|___|___|			
58. Type of proof submitted that you are a duly appointed Representative:				

Name:		SSN or EIN:		Claimant #:	

SECTION VII. METHOD OF PAYMENT

Complete this section to choose how you would like to receive your payment. You may choose to receive payment by check or by a direct wire deposit/electronic fund transfer into your account. Payments made by wire will be made from the New York, NY area. Based on your selection, complete the appropriate section below. Do not complete both sections. Legally enforceable garnishments, liens, or similar forms of attachments relating to your claim will be honored and deducted from your payment. The GCCF will report annually to federal and state taxing authorities, using a form 1099 or state form equivalent, for certain payments made. The GCCF will send you a copy of that form, but cannot give you tax advice regarding any payment issued to you. You should consult with your own tax advisor to determine the impact of any payment you receive from the GCCF on your individual tax situation.

VII.A. Election to Receive Payment by Wire Transfer

Complete this section if you want to receive your payment by direct deposit/electronic fund transfer. If you want to receive your payment by check, do not complete this section.

Do you want to receive your payment by direct deposit/electronic fund transfer?	☐ Yes ☐ No

Bank to Which Wire is to be Sent:	Bank Name			
	Street			
	City	State	Zip Code	Country
Bank Telephone Number:				
Bank ABA/Routing Number:				

Account Name: *If the Account Name for your bank account differs from your name or the name of your business, please also explain the reason for the difference in the box to the right.*	
Account Number:	

VII.B. Election to Receive Payment by Check

Complete this section if you want to receive your payment by check. Checks will be sent by overnight courier and will be made payable to the Individual or Business Claimant who completes this Claim Form. (Be sure to provide your Street Address for overnight delivery.) If you want to receive your payment by wire transfer, do not complete this section.

65. Do you want to receive your payment by check?	☐ Yes ☐ No
66. If Yes, and you are an individual who does not have your own bank account, please review the Notice of Check Cashing Options accompanying this Claim Form. After reviewing this Notice, elect whether you prefer to receive one check or multiple checks:	☐ One Check ☐ Multiple Checks

Provide the address to which you would like the check(s) to be sent in the space below, if it differs from the address provided in Section II.

67. Payment Address:	Street			
	City	State	Zip Code	Country

Name:		SSN or EIN:		Claimant #:	

SECTION VIII. SIGNATURE

I certify that the information provided in this Interim Payment Claim Form is true and accurate to the best of my knowledge, and I understand that false statements or claims made in connection with this Interim Payment Claim Form may result in fines, imprisonment, and/or any other remedy available by law to the Federal Government, and that suspicious claims will be forwarded to federal, state, and local law enforcement agencies for possible investigation and prosecution.

By submitting this Interim Payment Claim Form, I consent to the use and disclosure by the Gulf Coast Claims Facility ("GCCF") and those assisting the GCCF of any information about me that it believes necessary and/or helpful to process my claim for compensation and any payment resulting from that claim, including any appeal of that payment, legitimate business purposes associated with administering the GCCF and providing adequate documentation for insurance coverage of responsible parties, and/or as otherwise required by law, regulation or judicial process. My consent also includes release to the GCCF by the relevant state unemployment compensation agency of any information regarding any unemployment benefits I received for periods of unemployment on or after April 20, 2010.

Signature:		**Date:**	___/___/____ (Month/Day/Year)
Printed Name:	First	Middle	Last
Title, if a business:			

Has anyone, other than a family member or an Attorney you identified in Section III, assisted you in the preparation of this Claim Form?	☐ Yes ☐ No
Name of individual and company, if applicable:	

How to Submit this Claim Form

Submit this Interim Payment Claim Form and the supporting documents to the GCCF by one of the following methods:

Regular Mail:
Gulf Coast Claims Facility
Kenneth R. Feinberg, Administrator
P.O. Box 9658
Dublin, OH 43017-4958

Overnight, Certified or Registered Mail:
Gulf Coast Claims Facility
Kenneth R. Feinberg, Administrator
5151 Blazer Pkwy., Suite A
Dublin, OH 43017

Fax:
1-866-682-1772

Email Attachment:
info@gccf-claims.com

When attaching your supporting documents, be sure to provide the appropriate identification number (your Claimant Identification Number, Social Security Number, or other Tax Identification Number). Attach all supporting documents to the Claim Form and submit your claim to the GCCF.

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